



COVID-19 Virtual Press conference transcript - 12 October 2020

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Overview

COVID-19

Virtual Press conference 12 October 2020

Speaker key:

FC	Fadela Chaib
TAG	Dr Tedros Adhanom Ghebreyesus
KA	Kai
SS	Dr Soumya Swaminathan
BI	Bianca
MR	Dr Michael Ryan
MK	Dr Maria Van Kerkhove
AN	Anias

TI Tim
ST Stephanie
SO Sophie
SI Simon
BA Bayram
MS Dr Mariangela Simao
GA Gabriela

00:00:00

FC Hello, everybody. This is Fadela Chaib speaking to you from Geneva and welcoming you to our global COVID-19 press conference today, Monday, 12th October. I am happy to be moderating today's press conference. As always we have present in the room Dr Tedros, the WHO Director-General. Joining Dr Tedros are Dr Mike Ryan, Executive Director, Health Emergencies, Dr Maria Van Kerkhove, Technical Lead, COVID-19; present also in the room Dr Soumya Swaminathan, Chief Scientist, Dr Mariangela Simao, Assistant Director-General, Access to Medicines and Health Products. Dr Bruce Aylward will be joining very shortly.

The press briefing is being translated simultaneously into the six official UN languages plus Portuguese and Hindi. Now without further ado I will hand over to Dr Tedros for his opening remarks. Dr Tedros, please, you have the floor.

TAG Thank you. Thank you, Fadela. Good morning, good afternoon and good evening. Around the world we're now seeing an increase in the number of reported cases of COVID-19, especially in Europe and the Americas. Each of the last four days have seen the highest number of cases reported so far. Many cities and countries are also reporting an increase in hospitalisations and intensive care bed occupancy.

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At the same time we must remember that this is an uneven pandemic. Countries have responded differently and countries have been affected differently. Almost 70% of all cases reported globally last week were from ten countries and almost half of all cases were from just three countries.

For every country that's experiencing an increase there are many others that have successfully prevented or controlled widespread transmission with proven measures. Those measures continue to be our best defence against COVID-19. There has been some discussion recently about the concept of reaching so-called herd immunity by letting the virus spread.

Herd immunity is a concept used for vaccination in which a population can be protected from a certain virus if a threshold of vaccination is reached. For example herd immunity against measles requires about 95% of the population to be vaccinated. The remaining 5% will be protected by the fact that measles will not spread among those who are vaccinated. For polio the threshold is about 80%.

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In other words herd immunity is achieved by protecting people from a virus, not by exposing them to it. Never in the history of public health has herd immunity been used as a strategy for responding to an outbreak let alone a pandemic. It's scientifically and ethically problematic.

First we don't know enough about immunity to COVID-19. Most people who are infected with the virus that causes COVID-19 develop an immune response within the first few weeks but we don't know how strong or lasting that immune response is or how it differs for different people. We have some clues but we don't have the complete picture.

There have also been some examples of people infected with COVID-19 being infected for a second time. Second, the vast majority of people in most countries remain susceptible to this virus. Seroprevalence surveys suggest that in most countries less than 10% of the population have been infected with the COVID-19 virus.

Letting the virus circulate unchecked therefore means allowing unnecessary infections, suffering and death. Although older people and those with underlying conditions are most at risk of severe disease and death they're not the only ones at risk. People of all ages have died.

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Third, we're only beginning to understand the long-term health impacts among people with COVID-19. I have met with patient groups suffering with what is now being described as long COVID to understand their suffering and needs so we can advance research and rehabilitation.

Allowing a dangerous virus that we don't fully understand to run free is simply unethical. It's not an option but we do have many options. There are many things that countries can do and are doing to control transmission and save lives. It's not a choice between letting the virus run free and shutting down our societies. This virus transmits mainly between closed contacts and causes outbreaks that can be controlled by implementing targeted measures.

Prevent amplifying events, protect the vulnerable, empower, educate and engage communities and persist with the same tools that we have been advocating since day one; find, isolate, test and care for cases and trace and quarantine their contacts.

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This is what countries are proving works every day. Digital technologies are helping to make these tried and tested public health tools even more effective, such as mobile applications to support contact tracing efforts.

Germany's Corona-warn app has been used to transmit 1.2 million test results from labs to users in its first 100 days. The Arogya set-up from India has been downloaded by 150 million users and has helped city public health departments to identify areas where clusters could be anticipated and expand testing in a targeted way.

In Denmark more than 2,700 people have been tested for COVID-19 as a result of notifications received through a mobile application and the United Kingdom has rolled out a new version of its NHS COVID-19 app which had more than ten million downloads within the first week.

As well as alerting users that they may have been exposed to a positive COVID-19 case the app allows users to book a test and receive results, keep track of the places they have visited and receive the latest advice on local restrictions. WHO is working with the European Centre for Disease Prevention and Control to help countries evaluate the effectiveness of their digital contact tracing applications.

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This is just one example of the innovative measures countries are taking to control COVID-19. There are many tools at our disposal. WHO recommends case finding, isolation, testing, compassionate care, contact tracing, quarantine, physical distancing, hand hygiene, masks, respiratory etiquette, ventilation, avoiding crowds and more.

We recognise that at certain points some countries have had no choice but to issue stay-at-home orders and other measures to buy time. Many countries have used that time to develop plans, train health workers, put supplies in place, increase testing capacity, reduce testing time and improve care for patients.

WHO is hopeful that countries will use targeted interventions where and when needed based on the local situation. We well understand the frustration that many people, communities and governments are feeling as the pandemic drags on and as cases rise again.

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There are no shortcuts and no silver bullets. The answer is a comprehensive approach using every tool in the toolbox. This is not theory. Countries have done it and are doing it today successfully. My message to every country now weighing up its options is you can do it too. I thank you.

FC Thank you, Dr Tedros. We will now open the floor to questions from journalists. I remind you that you need to raise your hand, use the raise your hand icon in order to get into the queue to ask questions. I would like also to remind journalists to ask please only one question to allow for more journalists to intervene.

Let's start with the first question from Kai Kupferschmidt from Science. Kai, can you hear me?

KA Yes, thank you very much, Fadela. This is probably for Bruce Aylward. I'm not sure whether he's joined already. I wanted to ask whether you can give a quick update on where the COVAX facility stands both in terms of who has signed the commitment and in terms of the vaccines contracts that have been signed.

FC Thank you, Kai. Can we come back to you later on? Bruce is in a meeting but maybe Dr Soumya Swaminathan can take this question.

00:11:49

SS Yes, thank you, Kai. The COVAX facility is going from strength to strength. October 9th was another deadline for countries to make commitments and over the weekend we have over 180 countries that have committed. These include these self-financing countries and the latest one to join and make a public announcement was China and then you have the 92 AMC countries which will be eligible for GAVI support for the vaccines.

So actually when you add up all of these countries together they represent 90% of the world's population so it looks as if the COVAX facility has really brought countries and people together and it sets a good example for believing in and trying to achieve equitable access to vaccines.

The second part of your question was about investment in vaccines, I think. The facility will be looking at the broad range of vaccines that are out there, all those that are being developed, particularly those in the late stages of clinical trials.

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As you know, CEPI has nine candidate vaccines in the portfolio that they have supported the R&D for. Three of those are in phase-three clinical trials but the COVAX facility will be looking at a number of other candidates as well as the data comes out of the trials and then they will be

making decisions on advance market commitments for several of those vaccines and again there'd be an external advisory committee that is going to advise the COVAX facility to make those investments.

So at the moment it's looking good. On the funding side there's still a shortfall. We need to get \$2 billion by the end of this year and another five billion next year to supply just the AMC 92 countries which will be able to provide them for up to about 16, 17% of their population.

So there's still a bit of fund-raising to be done but I think the commitment seems to be there. Thanks.

FC Thank you, Dr Swaminathan. I would like now to invite Bianca Rotier from Globo for the next question. Bianca, can you hear me?

BI Hi, Fadela. Can you hear me?

00:14:35

FC Very well. Go ahead, please.

BI Thanks a lot. Despite the fact that Brazil has reached two sad and very symbolic milestones in the last days like more than five million cases and 150,000 deaths the numbers are clearly declining. Can WHO now comfortably say that the pandemic in Brazil has already reached its peak and what lessons can Brazil learn from what we are experiencing now here in Europe with record numbers only months after their reopening? Thanks a lot.

FC Thank you, Bianca. I would like to invite Dr Ryan to take this question.

MR Yes, we are pleased to see the numbers stabilising and going down in Brazil but remember they're stabilising and going down from some very high numbers and there are still many people getting COVID-19 in Brazil and across the Americas.

While there has been an overall downward trend in Central and South America there are a number of countries in which that trend is still upwards. Again we congratulate the front-line health workers in Brazil for what has been a very, very long and continues to be a very long fight and also the communities in Brazil for continuing to work to try and reduce the spread of this disease.

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But as we've all learnt at the school of hard knocks over the last number of months, the fact that disease is on the way down does not mean that disease will not pick up again and very, very quickly in certain circumstances so we need to remain vigilant in all countries and there needs to

be a high index of suspicion as the numbers go down to make sure you detect areas in which the numbers may be going up.

Brazil is a very, very large country; it's almost the size of half a continent so saying that the disease is on the way down in Brazil is a positive thing but that does not mean in other certain areas that the disease is not on the way up and therefore local authorities, state authorities will have to remain vigilant over time.

So yes, we're always glad when a country like Brazil that has so many people and contributes so much to the global economy and global culture is gaining some success but no country is out of the woods yet and everyone needs to remain vigilant.

00:17:11

FC I think Dr Van Kerkhove would like to add something.

MK Yes, just very briefly, not specific to Brazil but to all countries in that where we are in this pandemic right now and what we have learned - and Brazil is no different - is that we're so far advanced in terms of our knowledge about how to deal with this virus and, as we've stated, there is a decline that we're seeing in Brazil and in a number of countries while in others we are seeing a resurgence.

I think the knowledge that we've all gained on not just what to do but how to implement this is just as important and so this feedback mechanism about looking at how all of these interventions have been applied in each country at the subnational level and how those measures were put in place, how the measures are being adjusted as we go through this calibration period of opening up societies while keeping transmission at a low level, while applying the tools we have for active surveillance and case finding is really quite critical.

That feedback loop, that learning loop needs to be constant and I think all of us remain humble to this virus and the fact that we don't know everything but we know a heck of a lot more than we did a few months ago and I think that motivation of getting us to take that knowledge and be empowered by that to say, what we are doing is having an effect, what we are doing is saving lives; I think that mechanism by which a country, a subnational level can use that to drive yourself forward needs to be used because there are so many tools that you all have, that we all have that are working.

00:18:48

I think finding what works and how it works at that most localised level is really what is critical right now but, as Mike has said, we need to remain ready, we need to not become complacent, we need to be ready to quickly find as many cases as we can and especially those clusters because this virus likes to transmit between people in close contact with one another, it likes to

cause outbreaks and if we know where those outbreaks are going to happen and we have clues on this because those outbreaks happen in enclosed settings, they happen where people spend prolonged periods of time together, oftentimes where there's poor ventilation; if we can prevent that from happening we can get ahead of this virus and we can prevent even clusters of cases becoming community transmission again.

00:19:36

So well done to all of the countries that are working so incredibly hard and who are continuing to fight against this and to bring transmission under control.

FC Thank you. I would like now to give the floor to Anias Pederero from Agence France Press. Anias, can you hear me?

AN Yes, good evening, everybody.

FC Hi, Anias. Go ahead.

AN Good evening. Hello. This is a question to Dr Ryan. Last week Dr Ryan announced - it was last Monday - that 10% of the world's population might be infected by the COVID so the first question would be how do you get to that figure. With so many people infected do you suppose the fatality rate is much lower than we thought before and similar to the flu fatality rates?

So the question is, can we still say that COVID is more worrying than the flu?

MR Hi. Thanks for your question.

AN Thank you.

00:20:43

MR I made my remarks, I believe, at an executive board meeting with our member states where what I was actually trying to communicate was that the vast majority of human beings on this planet remain susceptible to the virus. I believe what I said was that many studies had demonstrated that 10% or less of people had been infected although that was very variable with some slum areas, high-risk populations like health workers being much higher.

So I was using that 90/10 as an illustration of the fact that most people in the world were susceptible. In fact in many countries that seroprevalence is very low but again what you have to remember is some of those seroprevalance studies were done a number of months ago.

What we currently have is a lot of work going on to summarise all of the serologic studies that have been done. We also have a series of unity studies which are longitudinal studies which are studying seroprevalance around the world or the number of people who have been infected much

more systematically.

So from that perspective you can say that, if you look at some of these studies, on average 10% or less; in some it's much less and in some studies much more.

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My point was illustrative and we will be coming out with much more detailed data as we make our estimates more accurate. I don't know, Maria, if you want to speak to that issue of how we're looking at the data right now.

MK Thanks, Mike. Yes, as you've heard us say many times before, we're looking at these seroepidemiology studies that are occurring globally. We are looking at a number of ways. First of which, we're looking at the publications that are coming out. These are peer-reviewed publications, pre-prints, government reports and to date there's more than 150 published reports from such studies that Mike has just referred to.

These are done various ways using various methodologies. Some are looking at populations, some are looking at stored clinical samples from people who have shown up at hospitals, some are from blood donors and others are done in specific types of populations; among health workers for example, in specific areas where there was high transmission in slums or in some cities and towns where there were really intense outbreaks.

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The results indicate across all of these 150 studies that, as Mike has said, the vast majority are below 10% with the exception of some high-incidence areas that are above 20/25% and some even higher.

So the point is that these studies continue to tell us that the vast majority of the world's population remains susceptible. The way in which we're trying to get a more standardised approach to look at studies and be able to pool these results and combine these results is through what we call the unity studies.

This is a series of six protocols that WHO has developed with many, many partners and in fact over the last 11 years because this work began with influenza, because we knew the importance of really trying to understand the extent of infection as measured through these seroepidemiology studies and the need to standardise this approach, use the same approach across multiple countries so that we can better compare what is happening in one country and another.

So WHO with our partners has developed six protocol templates for different types of populations and we're working with more than 50 countries right now to implement these studies where we are providing technical support on the adaptation of the protocol for the local context.

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We're providing support in working with the countries who are running these studies themselves to carry them out and many of these are underway. With the use of a standardised protocol what we can do when these results are finished and with the permission of the principal investigators of those is to be able to compare those and pool those and this will help us get a good global estimate of what is happening in different populations.

You also mentioned infection fatality ratio. In addition to this there are a number of statistical groups, mathematical modelling groups that are looking at the infection fatality ratio which is the number of deaths divided by the number of estimated infections.

There are several papers that have come out that are looking at this. Several of these analyses have used published or pre-print seroepidemiologic results and they all converge around a point estimate of around 0.6%.

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That may not sound like a lot but that is a lot higher than influenza and the infection fatality ratio increases dramatically with age so we can provide you with these papers, these papers are published but there is a big increase in the infection fatality ratio by age but overall these converge around 0.6%.

FC Thank you. I would like now to invite a Bloomberg reporter for the next question, Tim Loh from Bloomberg. Can you hear me, Tim?

TI Yes, can you hear me?

FC Yes, very well. Go ahead, please.

TI All right. Thank you. My question has to do with the recent upsurge in Europe right now. Even in countries like Spain where the current wave of infections is hitting especially hard hospitalisations during the virus are still far lower than they were at the peak of the first wave. I'm just looking for an update on your current thinking as to why this is and what risk factors might cause this trend to worsen in the coming weeks or months.

FC Thank you, Tim. Dr Ryan.

00:26:33

MR I'll start. Maria will likely add. Currently, as we've seen in all cases of rising incidence so far in this pandemic, the incidence of hospitalisation and deaths lags behind the incidence of cases themselves and it takes a number of weeks usually for those numbers to feed through into the system.

But we also recognise that within that that lag has been over a longer period of time and it may reflect a shift in the age distribution of cases or at least of tested cases with more disease in younger age groups who don't tend to be as hospitalised or don't tend to have fatal outcomes; that's certainly a factor.

But what we are beginning to see, worryingly, in places like France, the UK, Ireland and other countries is hospitalisation rates increasing, ICU occupancy rising and it's really important that health systems are able to cope with what will be an increasing number of cases in hospital and ICUs over the coming weeks.

The question remains as to how many of those daily incident cases convert into hospitalisations and then into very seriously ill patients and we don't know that for sure.

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If this trend continues, yes, it could be down to the age base. In terms of people going into ICU or even being hospitalised, again Maria may speak to this but we've learnt a lot about how to recognise early symptoms of the disease, how to ensure that patients who are vulnerable are better protected and those that are vulnerable get access to early treatment.

I think a lot of this is making sure that those people most likely to fare badly are in a clinical pathway that gets them into intensive care or supported care much more quickly. We all saw back in March and April people on hospital trolleys, great difficulties in triaging patients, patients who probably needed immediate care not getting immediate care.

Therefore the streamlining and efficiency of the system is very, very important and that efficiency drops as the system comes under pressure. It's a great testament that particularly people working in emergency rooms in the front end of our systems have really improved the way in which we streamline the clinical pathways in the hospital to ensure that the sickest patients or those most likely to become sicker are getting access to care quickly.

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We then add in the advent of therapeutics like dexamethasone and the use of high-flow oxygen, oxygen concentrators, so many other things that have come on stream. So I think overall clinical care is improving, which won't reduce hospitalisation rate per se but certainly will reduce death rates so a number of factors in that.

It may also be - and this is something that remains to be explored, whether or not the very fact that people have been more socially distanced, the very fact that people are taking more care with hygiene, whether or not people are being exposed to a lower infectious dose and that is something that's still very, very speculative and it's something that will be explored and is being explored as we speak.

But the reality is that we may not be perfectly effective at reducing transmission between people but there is a link between the infectious dose, the amount of virus you're exposed to and the severity of your illness or your likelihood to become sick; again a lot of work going on on that.

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I believe in the end it will turn out to be multifactorial, there will have been many reasons but I think we need to be really careful right now not to make an assumption that the current disconnect between the rising number of cases and deaths; that could reconnect very, very badly and very catastrophically unless we're very, very careful.

MK Thanks. Mike, I think you described it perfectly but, as you said, it's a combination of factors that we're seeing happen across Europe and in fact a number of countries where we're seeing a lower mortality rate compared to the beginning of this pandemic and part of it is due to surveillance because we are able to test more, we are able to expand our surveillance beyond just severe patients, beyond just individuals who show up at healthcare.

This is a hallmark of outbreaks and pandemics; in the beginning you tend to focus on severe patients because that is what your system can cope with and so as surveillance expands, we are able to test more, we're able to do contact tracing we tend to find more individuals who are on the more mild end of the spectrum so that's one.

Second, through these second peaks that we are seeing in a number of countries there is an age shift in the average age of cases that we are detecting and part of that is because as societies are opening up individuals are coming away from those stay-at-home measures, they're going back to work, there's a lot of socialising that is happening.

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Unfortunately in some of those situations the virus really, really likes this type of setting and can spread and we have seen quite a few outbreaks in a number of countries across entertainment-type settings, across religious settings, across sporting events and that will drive the age down.

We know that younger individuals tend to have less underlying conditions and they don't develop as much severe disease as someone who is older. But also we are getting better at preventing outbreaks happening in vulnerable populations.

The long-term living facilities for example in some countries were incredibly devastating in the beginning and unfortunately are still happening in some countries but if we could prevent the virus from entering a long-term living facility for example we could prevent amplification, we could prevent severe disease and death.

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The other side of this coin is that we are getting much better at dealing with patients. Clinicians, nurses, front-line workers have experience with COVID-19 now, they are better trained, they are better experienced and we know and they know from the hard work that they have dealt with to save lives.

So earlier testing means earlier access to clinical care, it means checking that oxygen level in that individual quicker, it means providing oxygen quicker when needed, it means providing ventilatory support if necessary, providing dexamethasone for people who are severe and who are critical and all of that saves lives.

So we're getting much better at actually dealing with patients and treating patients and caring for them, which is leading to more positive outcomes. But the one thing we worry about - and I know we've said this many times - one of the things that we worry about; it's not just numbers of cases, it's not just hospitalisations and deaths; it's about all of the long-term impacts that we are starting to see in individuals who even had a mild infection, a mild disease.

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We are only now starting to really learn of the long-term impacts on the heart, on the brain, on the lungs, on mental health, on people's ability to recover from COVID infection. So not only do we need to work very hard at reducing mortality - and we are seeing the benefits of that.

We still need to reduce the numbers of infections that we are seeing and again we come back to all of the tools that are in place to be able to do this. We can do it all, we can do this all together because we are all in this together and it's about individual measures that we take to protect ourselves and having the enabled environment for us to take those to protect ourselves and our loved ones.

FC Thank you. I would like now to invite Stephanie Nebahe from Reuters. Stephanie, can you hear me?

ST Yes, thank you for taking our question. I wondered whether... As you probably know, Australian researchers today said in a study that was published earlier today that the SARS-CoV2 virus can survive on bank notes and glass and stainless steel for up to 28 days, which is quite a bit longer than the flu virus.

00:35:07

So what can WHO say about the transmissibility from such surfaces please over such long periods of time and do you have any increased concerns or new advice following this study that was published today? Thank you.

FC Thank you, Stephanie. I would like to invite Dr Van Kerkhove to take this question. Dr Van Kerkhove, you have the floor.

MK Thanks, Fadela. Thanks, Stephanie, for this question. Yes, we're aware of the study that was published. This was an experimental study that was looking at the SARS-CoV2 virus. It looked at samples that had very high viral loads. There are other studies that have been done under experimental conditions and of course we look at those studies to look at our advice and look at how we make recommendations for disinfectants.

What the study found; it was done under experimental conditions so not real-world conditions. It was done in the dark, which means it didn't have any UV light, what you would see under normal real-world-type situations.

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It found that the virus could remain viable for 28 days at 20 degrees Celsius and 24 hours at 40 degrees Celsius and it looked at different types of surfaces like glass and stainless steel and paper and polymer bank notes.

So we use this information to look at our disinfectants. The good news is that this virus can be disinfected with disinfectants, with chlorine, with different types of... very, very quickly and we know that fomites or touching a contaminated surface is one of the ways this virus can transmit.

So what we worry about is if someone is infected and they release the virus and it falls onto a surface if it isn't disinfected and someone touches that surface and if they don't wash their hands or use an alcohol-based rub, if they touch their eyes or their nose or their mouth they can infect themselves that way.

So we continue to recommend these basics, we continue to recommend that there's environmental cleaning that is happening in areas where there're known patients of course, in hospitals and in homes where people are being cared for but also making sure that we disinfect surfaces regularly.

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Again there's good news that disinfectants like bleach work very well at removing the virus and they're very highly effective at killing this virus so the measures remain in place; hand hygiene, carry your alcohol-based rub, make sure that you use it because that will clean your hands and remove the virus from your hands before you can infect yourself.

MR Just on that, the very basis of hand hygiene - and I go back to the old soap-and-water argument as well; soap and water is probably one of the most effective public health interventions that's ever been invented because it does everything from getting rid of all kinds of bacteria, all

kinds of viruses on your hands and prevents the spread of any number of diseases from cholera to coronaviruses.

So I think having access to soap and water, having access to hand sanitiser and coming back to those basic messages that we've been speaking about for months since the very beginning about hand hygiene and not to forget hand hygiene...

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I've seen this myself and personally witnessed it and I'm very, very pleased to see the adherence to masks and to physical distancing and then I've witnessed many times people have access to hand hygiene stations going in and out of shops or public transport and they don't tend to use it because they've made an association that in some way this disease is only spread through droplets or only spread through other means.

In fact this disease can be spread through contamination of surfaces however long those surfaces are contaminated for so it's very, very important that we continue and again the DG has spoken about this many times; do it all and that includes hand hygiene, that includes washing your hands as regularly as you can; not so easy for many people in the world who don't have access even to soap and water to be able to do that.

That is a huge injustice in the world, not only for the case of coronavirus but for so many other diseases. So I would just say to everybody, hand hygiene is a major part of coronavirus control. This study only reinforces that. We will see, as Maria says, in the long term what the implications of this and other studies are but the message is wash your hands often with soap and water or use sanitiser when you can.

00:39:51

FC Thank you very much. I would like now to invite Sophie from SABC, South Africa Broadcasting Company. Sophie, can you hear me?

SO Yes, I can hear you. My question is directed to Dr Ryan and Dr Tedros. We have a situation where most countries are currently going to election. For example on the continent you have Ivory Coast, you have Tanzania in two weeks' time. You also have the United States of America and there you look at what leaders are doing in terms of their rallies and their campaigns.

You have these large numbers. Are you not worried that this will lead to cluster outbreaks?

MR Elections do many things. They're an essential part of our lives and they're absolutely central to how many societies live, survive and thrive, they're a very important part of the cycle of life. However they do tend to bring people together and we've seen many examples over the last

nine months where elections have actually been held very safely and with appropriate measures and have been straightforward enough to manage and implement.

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It takes effort. We've worked very closely in the past in the same way we've done for all types of mass gatherings. We've worked on a risk management approach. You cannot reduce the risk to zero but what you can do is identify and manage those risks, especially where in-person voting is the choice of the country.

We don't specify to any country what the proper choice is for the type of election they need to run. That is based on their own risk assessment but we do offer them advice on how to reduce those risks if in-person elections are the way forward and in fact we're working right now on finalising specific guidance for countries who choose in-person elections, learning from the last eight, nine months as to what has worked in those circumstances and we'll be issuing that guidance in the coming days.

It's a very important question but like any form of gathering, any form of social process at society level it is possible to manage them and reduce risk to an absolute minimum if everybody participates and if everybody adheres to what is an agreed method and agreed practice.

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The problem very often is when those practices are ignored and that's essentially something that can't be legislated for but it is possible to hold safe elections if the proper measures are put in place.

FC Thank you, Dr Ryan. I would like now to invite Simon Ateba, Africa News Today, to ask the next question. Simon, can you hear me?

SI Yes, I can hear you. Thank you for taking my question. This is Simon Ateba from Today News Africa in Washington DC. I know it's really hard for WHO to talk about specific member, especially the US and especially President Trump, especially with 22 days until an election.

But on Thursday last week, 11 days ago, he tested positive for coronavirus and he's gone back on the campaign trail. I was wondering, first according to WHO guidelines how long does the virus take in the system, when does it know that it's no more a risk to other people, especially because he has not done a second test, it has proven that he's tested negative?

00:43:35

I was also wondering, what's the best way to go back on the campaign trail after testing positive for coronavirus. Thank you.

MR Simon, that's a lot of questions and we're certainly not the personal physicians to anyone in the world and would not like to make a comment on specific individuals.

What we can say is that the US public health services have very clear criteria in place for what represents the release of an individual from what might be isolation due to being infected and the criteria in the US - Maria may outline them - are very clear.

From WHO's perspective we allow both testing and duration of number of days since the onset of symptoms; both approaches are used to WHO or offered to our member states as mechanisms. I believe Maria is ten days from the onset of symptoms plus three days from the onset of the cessation of the last symptoms.

Again all countries have adapted that according to their national protocols and therefore we would not comment on whether any specific individual meets the requirements of their national protocol. Maria?

00:44:52

MK Thanks. Yes, I can tell you exactly what Mike has said; for symptomatic individuals it's ten days from the time of symptom onset plus the three days of symptom resolution, meaning no fever, no respiratory symptoms. We also have criteria for asymptomatic individuals.

But what we do is we work with countries all over the world, we work with labs all over the world to look at when people test positive using PCR testing but also looking at virus isolation from those individuals and there are a handful of studies that have been underway.

We've outlined our understanding of the science in a scientific brief on this, which is on our website and we are continuing to work with labs who are following patients and individuals over time. So this is a body of work that is very important for us; we work with our counterparts in the US as well.

FC Thank you so much. I would like now to invite Bayram Altuk from Anadolu News Agency for the next question. Bayram, can you hear me?

BA Yes, I can hear you. Thank you, Fadela, for taking my question and good evening to everyone. The eyes of the whole world are on the good news from WHO about the COVID-19 vaccine.

00:46:07

From WHO's perspective where do we stand with the vaccine development as a number of countries say they are on the cusp of having a successful vaccine like China, Russia, USA, UK and today Turkey. So when will we get a safe and effective vaccine at the earliest, what is your latest update on this? Do you have any good news for us today? Thank you.

FC Thank you, Bayram. I would like to invite Dr Swaminathan to answer this question.

SS Yes, thank you for that question. We of course continue to track the development of vaccines and it's really very encouraging to see the progress in the clinical trials happening all around the world.

As you know, we have about 40 vaccine candidates now in some stage of clinical trials and ten of them are in the phase three trial, which are the late-stage clinical trials which will tell us about both the efficacy and the safety.

00:47:06

So the best that we could make a guess or predict, looking at when a trial started and when it is likely to have enough data to submit to the regulators; the earliest is starting from December of 2020 into the early part of 2021.

We expect a number of clinical trials to start providing data for regulators to look at and this is going to be a lot of data for regulators and also the WHO. Dr Simao's here; she may want to add but we also put out a call for expressions of interest from vaccine developers to submit whatever data they have to us and so have a rolling submission and update us.

But unless we see results from phase three trials... So as said, the majority of the ones which are currently in phase three trials will be reporting in the early part of 2021 and beyond, it will continue because many others are going to enter into phase three over the next few months.

So the good thing is we'll have a number of different vaccine trial results that we will be looking at over a period of the next, I think, six to 12 months and then both regulatory agencies and the WHO will have to make decisions on either emergency use authorisation or on regular licensing of the vaccines depending on the data set that they're able to provide.

00:48:36

So I think in the first quarter of 2021 is when we are going to see most of the data coming in. Thanks.

FC Thank you, Dr Swaminathan. I think Dr Simao would like to add some information.

MS Yes, thank you, Fadela, and thank you for the question. I think there are other issues that will come into play as well. Dr Soumya Swaminathan referred to the regulators part. Once you finalise a phase three trial vaccine will need to be licensed if it proves positive, proves safe on the safety side and the efficacy side.

This vaccine will have to be licensed in the country where it's being experimented... where the trial took place and we also have the manufacturing capacity. It will need to be available to be used at country level so there are many steps that need to be taken after the phase three trial actually ends.

00:49:43

WHO is working very closely with the national regulatory authorities and, as Dr Swaminathan referred to, we issued an expression of interest for the emergency use listing of a vaccine and we are accepting any producer, any candidate vaccine that's in phase 2B or phase three and we expect this will help to move the process faster as we get the dossiers and we start to analyse not only the efficacy and safety but we work at the same time with a good manufacturing capacity at each of these vaccine producers so that when the vaccine has finally concluded the trials we do have a clear vision of the quality assurance of the product that will come to the market.

So I think we will be ready when we're ready but we're getting there. Thank you.

FC Thank you, Dr Simao. I would like now to invite Gabriela Sotomayor from Procesa to ask the next question? Gabriela, are you online?

GA Yes, thank you very much for taking my question. I would like to know about the forecast in Mexico. The first wave is not over yet, the cases are still on the rise, few tests are done. There are more than 80,000 deaths but it's possible that there are three times more deaths so Mexico is one of those ten countries that Dr Tedros just mentioned.

00:51:23

So I would like to know what recommendations you have. There is also another serious problem because about 1,000 children with cancer have died due to the lack of treatment, a problem that began to appear in public hospitals before the pandemic.

So that is the situation; I would like to know what is your recommendation and your forecast for the country. Thank you.

MR Hi. Thanks. Yes, the situation in Mexico obviously remains difficult. Until October 10th there were over 814,000 cases and over 83,600 deaths from COVID. Again I think putting it in context, nearly half of all the confirmed cases have come from Mexico City and the state of Mexico, Nuen, Leon, Guanajuato and Sonora so in that sense there's been a big impact in certain areas.

About a quarter of the patients reported to us have required hospitalisations and there's been a preponderance of males over females, about 52% to 48% but not such a great preponderance. Again many people, like we've seen all over the world, have had underlying conditions;

hypertension, diabetes, obesity were the main associated conditions there.

00:53:02

Mexico's been running this three-level traffic light system and interestingly many other countries have adopted similar traffic light systems in the last number of months. Mexico was one of the first countries in the Americas to introduce that traffic light system and we would support Mexico in continuing to do that.

Health personnel have been very much affected in Mexico and again predominantly 60% reported in females, which probably represents the fact that health workers in Mexico are predominantly female themselves; 48% of the cases in nurses, about a quarter of the cases in doctors and another quarter in other health professionals in Mexico.

Clearly protecting those health workers is very important and we have, our PAHO office have obviously continued to recommend to Mexico to continue the training, protection and provision of equipment to front-line health workers in Mexico.

Again the same issues arise in terms of the shift of disease into younger populations. There have been issues in the past on the testing strategy and the amount of testing done. I'd also like to commend Mexico; it's been very careful to try...

00:54:20

It's had a large bump of cases over the weekend, just before the weekend because it's actually changed a lot of its definition of cases, not to reduce the number of cases; to actually capture more cases, particularly those who weren't tested.

So Mexico now considered cases who are epidemiologically associated with a confirmed case to be cases and the same with deaths, which actually puts Mexico in a situation where it will tend to report more cases than elsewhere and it is to be commended for its transparency on that.

So I would say, yes, no more than many other countries in North, Central and South America no country is out of the woods. Mexico continues to be in difficulty and it is very tragic to hear your reporting on cancer patients and we've seen this impact around the world on oncology services around the world, outpatient services and others for essential care.

00:55:17

In many ways - and I think the DG has said this many times before - COVID to an extent has caused some of these problems but it's also revealed huge inequities in the system. As you said, many of these issues may have been present before so Mexico, no more than every country in the world, has serious inequities in the way healthcare is delivered and the way healthcare is paid for. It is tragic to hear in any country that children would die unnecessarily from treatable cancers.

FC Thank you, Dr Ryan. We are up to the hour now. I would like to invite Dr Tedros to make final comments. Over to you, Dr Tedros.

TAG Thank you. Thanks, Fadela, and thanks also to all who have joined today and see you in our next presser. Thank you.

FC Thank you, Dr Tedros. Just reminding journalists that we will be sending the audio file and Dr Tedros' remarks right after the press conference. The full transcript will be posted on the WHO website tomorrow morning. Sorry to journalists I wasn't able to take questions from due to time constraints. Don't hesitate to contact us. Thank you so much and see you soon.

00:56:48

WHO TEAM

WHO Headquarters (HQ)

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